26. Personal care services. (continued)

3) the administrative fee of the PCA Choice provider and services paid for with that fee, including background checks;

4) procedures to respond to billing or payment complaints; and

5) procedures for hiring and terminating the qualified professional and personal care assistant.

The PCA Choice provider:

a) enrolls in medical assistance;

b) requests and secures background checks on qualified professionals and personal care assistants according to the state human services licensing act;

c) bills for personal care assistant and qualified professional services;

d) pays the qualified professional and personal care assistant based on actual hours of services provided;

e) withholds and pays all applicable federal and state taxes;

f) makes the arrangements and pays unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

g) verifies and documents hours worked by the qualified professional and personal care assistant; and

h) ensures arm's length transactions with the recipient and personal care assistant.

26. Personal care services. (continued)

At a minimum, qualified professionals visit the recipient in the recipient's home at least once every year. Qualified professionals:

a) report to the county public health nurse concerns relating to the health and safety of the recipient; and

b) report to the appropriate authorities any suspected abuse, neglect, or financial exploitation of the recipient.

As part of the assessment and reassessment process in item 6.d.B. of this attachment, the following must be met to use, or continue to use, a PCA Choice provider:

a) the recipient must be able to direct the recipient's own care, or the responsible party for the recipient must be readily available to direct the care of the personal care assistant;

b) the recipient or responsible party must be knowledgeable of the health care needs of the recipient and be able to effectively communicate those needs;

c) the recipient cannot receive shared personal care services (shared services); and

d) a service update cannot be used in lieu of an annual reassessment.

Authorization to use the PCA Choice option will be denied, revoked, or suspended if:

a) the public health nurse or qualified professional determines that use of this option jeopardizes the recipient's health and safety;

b) the parties do not comply with the written agreement; or

26. Personal care services. (continued)

c) the use of the option results in abusive or fraudulent billing.

The recipient or responsible party may appeal this decision. A denial, revocation or suspension will not affect the recipient's authorized level of personal care assistant services.

Amount, duration and scope of personal care services:

- Department prior authorization is required for all personal care services and supervision. Prior authorization is based on the physician's orders; the recipient's needs, diagnosis, and condition; an assessment of the recipient; primary payer coverage determination information as required; the service plan; and cost effectiveness when compared to other care options. The Department may authorize up to the following amounts of personal care service:

  a) up to 2 times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level;

  b) up to 3 times the average number of direct care hours provided in nursing facilities for recipients with complex medical needs, or who are dependent in at least seven activities of daily living and need either physical assistance with eating or have a neurological diagnosis;

  c) up to 60 percent of the average payment rate for care provided in a regional treatment center for recipients who exhibit, or that without supervision, observation, or redirection would exhibit, one or more of the following behaviors:

     1) self-injury;
     2) physical injury to others; or
     3) destruction of property;

26. Personal care services. (continued)

d) up to the amount medical assistance would pay for care provided in a regional treatment center for recipients referred by a regional treatment center preadmission evaluation team; or

e) up to the amount medical assistance would pay for facility care for recipients referred by a preadmission screening team; and

f) a reasonable amount of time for the provision of supervision of personal care services.

- Department prior authorization is also required if more than two reassessments to determine a recipient's need for personal care services are needed during a calendar year.

- Personal care services must be prescribed by a physician. The service plan must be reviewed and revised as medically necessary at least once every 365 days.

- For personal care services

a) effective July 1, 1996, the amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers;

b) effective July 1, 1996, if the recipient's medical need changes, the recipient's provider may request a change in service authorization; and

c) as of July 1, 1998, in order to continue to receive personal care services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the Department. If a service update is completed, it substitutes for the annual reassessment described in item 6.d.B. of this attachment.

26. Personal care services. (continued)

- All personal care services must be supervised as described in this item. A reasonable amount of time for the provision of supervision shall be authorized.

- Personal care services are provided for recipients who live in their own home if their own home is not a hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), institution for mental disease, or licensed health care facility.

- Recipients may use approved units of service outside the home when normal life activities take them outside the home and when, without the provision of personal care, their health and safety would be jeopardized. Effective July 1, 1996, total hours for personal care services, whether performed inside or outside a recipient's home, cannot exceed that which is otherwise allowed for personal care services in an in-home setting.

- Recipients may receive shared personal care services (shared services), defined as providing personal care services by a personal care assistant to two or three recipients at the same time and in the same setting. For purposes of this item, "setting" means the home or foster care home of one of the recipients, a child care program in which all recipients served by one personal care assistant are participating, which has state licensure or is operated by a local school district or private school, or outside the home or foster care home when normal life activities take recipients outside the home or foster care home. The provider must offer the recipient or responsible party the option of shared services; if accepted, the recipient or responsible party may withdraw participation in shared services at any time.

  In addition to the documentation requirements for personal care provider service records in state rule, a personal care provider must meet documentation requirements for shared services and

26. Personal care services. (continued)

must document the following in the health service record for each recipient sharing services:

a) permission by the recipient or responsible party for the maximum number of shared services hours per week chosen by the recipient;

b) permission by the recipient or responsible party for personal care assistant services provided outside the recipient's home;

c) permission by the recipient or responsible party for others to receive shared services in the recipient's home;

d) revocation by the recipient or responsible party of the shared service authorization, or the shared service to be provided to others in the recipient's home, or the shared services to be provided outside the recipient's home;

e) supervision of the shared personal care assistant services by the qualified professional, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, and shared services scheduling issues and recommendations;

f) documentation by the qualified professional of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient; and

g) daily documentation of the shared services provided by each identified personal care assistant including:

1) the names of each recipient receiving share services together;

26. Personal care services. (continued)

2) the setting for the shared services, including the starting and ending times that the recipient received shared services; and

3) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional.

In order to receive shared services:

a) the recipient or responsible party, in conjunction with the county public health nurse, must determine:

1) whether shared services is an appropriate option based on the individual needs and preferences of the recipient; and

2) the amount of shared services allocated as part of the overall authorization of personal care services;

b) the recipient or responsible party, in conjunction with the supervising qualified professional, must arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients;

c) the recipient or responsible party, and the supervising qualified professional, must consider and document in the recipient's health service record:

1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;

26. Personal care services. (continued)

2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are appropriately and safely met. The provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter;

3) the setting in which the shared services will be provided;

4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and

5) a contingency plan that accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.

- The following personal care services are covered under medical assistance as personal care services:

a) bowel and bladder care;

b) skin care to maintain the health of the skin;

c) repetitive range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

d) respiratory assistance;

e) transfers and ambulation;

f) bathing, grooming, and hair washing necessary for personal hygiene;

g) turning and positioning;

26. Personal care services. (continued)

h) assistance with furnishing medication that is self-administered;

i) application and maintenance of prosthetics and orthotics;

j) cleaning medical equipment;

k) dressing or undressing;

l) assistance with eating, meal preparation and necessary grocery shopping;

m) accompanying a recipient to obtain medical diagnosis or treatment;

n) effective July 1, 1996, assisting, monitoring, or prompting the recipient to complete the services in items (a) to (m);

o) effective July 1, 1996, redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care described in items (a) to (n);

p) effective July 1, 1996, redirection and intervention for behavior, including observation and monitoring;

q) effective July 1, 1996, interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

r) effective July 1, 1998, tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure may be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean, rather than a sterile

26. Personal care services. (continued)

procedure, and must ensure that the personal care assistant has been taught the proper procedure. A clean procedure is defined as a technique reducing the numbers of microorganisms, or prevents or reduces the transmission of microorganisms from one recipient or place to another. It may be used beginning 14 days after insertion; and

s) incidental household services that are an integral part of a personal care service described in items a) to r).

- The above limitations do not apply to medically necessary personal care services under EPSDT.

- The following services are **not covered** under medical assistance as personal care services:

  a) health services provided and billed by a provider who is not an enrolled personal care provider;

  b) personal care services that are provided by the recipient's spouse, legal guardian, parent of a recipient under age 18, or the recipient's responsible party;

  c) personal care services that are provided by the recipient's adult child or sibling, or the adult recipient's parent, unless these relatives meet one of the hardship criteria, below, and receive a waiver from the Department. As of July 1, 2000, any of these relatives who are also guardians or conservators of adult recipients, when the guardians or conservators are not the owner of the recipient's personal care provider organization, are included in this list.

26. Personal care services. (continued)

The hardship waiver criteria are:

1) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

2) the relative goes from a full-time job to a part-time job with less compensation to provide personal care for the recipient;

3) the relative takes a leave of absence without pay to provide personal care for the recipient;

4) the relative incurs substantial expenses by providing personal care for the recipient; or

5) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient.

d) effective July 1, 1996, services provided by a foster care provider of a recipient who cannot direct his or her own care, unless a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met;

e) services provided by the residential or program license holder in a residence for more than four persons;

26. Personal care services. (continued)

f) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

g) sterile procedures;

h) giving of injections of fluids into veins, muscles, or skin;

i) homemaker services that are not an integral part of a personal care service;

j) home maintenance or chore services;

l) personal care services when the number of foster care residents is greater than four;

m) personal care services when ~~combined with home health services, private duty nursing services, and foster care payments that exceed the total amount that public funds would pay for the recipient's care in a medical institution. This is a utilization control limitation conducted on a case-by-case basis in order to provide the recipient with the most~~ other, more cost-effective, medically appropriate services are available;

n) services not specified as covered under medical assistance as personal care services;

o) effective January 1, 1996, assessments by personal care provider organizations or by independently enrolled registered nurses;

p) effective July 1, 1996, services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care

26. Personal care services. (continued)

assistant, unless case management is provided (applies to foster care settings);

q) effective January 1, 1996, personal care services that are not in the service plan;

r) home care services to a recipient who is eligible for Medicare covered home care services (including hospice), if elected by the recipient, or any other insurance held by the recipient;

s) services to other members of the recipient's household;

t) any home care service included in the daily rate of the community-based residential facility where the recipient resides;

u) personal care services that are not ordered by the physician; or

v) services not authorized by the commissioner or the commissioner's designee.

26. Personal care services. (continued)

b) assessments, reassessments and service updates are not required;

c) Department prior authorization is not required;

d) a physician need not review the IEP;

e) a personal care assistant is supervised by a registered nurse, public health nurse, school nurse, occupational therapist, physical therapist, or speech pathologist;

f) service limits as described in this item do not apply;

g) PCA Choice is not an option;

h) only the following services are covered:

1) bowel and bladder care;

2) range of motion and muscle strengthening exercises;

3) transfers and ambulation;

4) turning and positioning;

5) application and maintenance of prosthetics and orthotics;

6) dressing or undressing;

7) assistance with eating, nutrition and diet activities;

8) redirection, monitoring, observation and intervention for behavior; and

9) assisting, monitoring, or prompting the recipient to complete the services in subitems 1) through 8).

26. Personal care services. (continued)

- To receive personal care services, the recipient or responsible party must provide written authorization in the recipient's care plan identifying the chosen provider and the daily amount of services to be used at school.

- School districts must secure informed consent to bill for personal care services. For the purposes of this item, "informed consent" means a written agreement, or an agreement as documented in the record, by a recipient or responsible party in accordance with Minnesota Statutes, section 13.05, subdivision 4, paragraph (d) and Minnesota Statutes, section 256B.77, subdivision 2, paragraph (p).

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

For level one HCPCS codes titled "office and other outpatient services", "preventive medicine new and established patient", "delivery, antepartum and postpartum care", "critical care", "cesarean delivery" and "pharmacological management" provided to psychiatric patients; and HCPCS level three codes for enhanced services for prenatal high risk, payment is the lower of:

(1) submitted charges; or

(2) (a) 80% of the 50th percentile of the charges submitted by all providers of the service (except for services provided by home health agencies, home and community based waiver services providers, IEP providers, dentists, and providers whose payment rate is based on a percentage of the physicians' payment rate) in the calendar year specified in legislation governing maximum payment rates; or

(b) State agency established rate.

Effective January 1, 2000, the rate is increased by three percent.

For all other services the payment rate is the lower of:

(1) submitted charges; or

(2) (a) 75% of the 50th percentile of the charges submitted by all providers of the service (except for services provided by home health agencies, home and community based waiver services providers, IEP providers, dentists, and providers whose payment rate is based on a percentage of the physicians' payment rate) in the calendar year specified in legislation governing maximum payment rates; or

(b) State agency established rate.

Effective January 1, 2000, the rate is increased by three percent.

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

Effective July 1, 1997, the State agency established rate is increased five percent for physical therapy services, occupational therapy services, speech-language therapy services, and respiratory therapy services. Effective July 1, 1998, the rate is increased three percent for these services, and effective January 1, 2000, the rate is increased another three percent.

The rates for respiratory therapy services are as follows:

Procedure Code	**Rate**
94640	$ 15.02
94642	19.02
94650	16.70
94651	14.48
94652	140.34
94656	100.24
94657	43.43
94660	100.24
94664	18.78
94665	12.93
94667	16.19
94668	16.19

If the service is provided by an **enrolled physician assistant**, the service is paid the lower of:

1) submitted charge; or

2) 90% of the reference file allowable.

If the service is provided by a **physician extender**, the service is paid the lower of:

1) submitted charge; or

2) 65% of the reference file allowable, except for psychology services that are provided by a nonenrolled mental health practitioner, in which case the service is paid the lower of the submitted charge or 50% of the reference file allowable.

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

Psychotherapy services are paid the lower of:

(1) submitted charge; or

(2) (a) 75% of the 50th percentile of the charges submitted by all providers of the service (except for services provided by home health agencies, home and community-based waiver services providers, IEP providers and providers whose payment rate is based on a percentage of the physicians' payment rate) in the calendar year specified in legislation governing maximum payment rates; or

(b) State agency established rate.

Effective January 1, 2000, the rate is increased by three percent.

If the service is provided by a nonenrolled mental health practitioner, the supervising enrolled provider is paid the lower of:

(1) submitted charge; or

(2) 50% of item (2)(a) or (2)(b), above, for psychotherapy services.

Anesthesia services personally performed by the anesthesiologist are paid the lower of:

(1) submitted charge; or

(2) the product of the physician conversion factor ($18.00) multiplied by the sum of the relative base value units and time units (one time unit equals fifteen minutes).

~~If the anesthesiologist medically directs one nurse anesthetist, the anesthesiologist is paid for the service as though it were personally performed.~~

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

~~If the anesthesiologist medically directs two to four concurrent anesthesia procedures performed by nurse anesthetists, the anesthesiologist is paid as follows:~~

~~(1) For two concurrent procedures: 90% of the relative base value multiplied by the physician conversion factor, plus time.~~
~~(2) For three concurrent procedures: 75% of the relative base value multiplied by the physician conversion factor, plus time.~~
~~(3) For four concurrent procedures: 60% of the relative base value multiplied by the physician conversion factor, plus time.~~

~~For items (1), (2) and (3), if the nurse anesthetists are employed by the anesthesiologist, time is paid at $2.40 per minute. If the nurse anesthetists are not employed by the anesthesiologist, time is paid at $1.20 per minute.~~

~~If the anesthesiologist directs (supervises) five or more nurse anesthetists, the anesthesiologist is paid the physician conversion factor multiplied by four.~~

Anesthesia services provided by the anesthesiologist medically directing (supervising) ~~residents or~~ one to four certified registered nurse anesthetists, student registered nurse anesthetists, or anesthesia residents are paid the lower of:

(1) submitted charge; or

(2) (relative base value units + time units) x ~~10.00~~ physician conversion factor)
2 x ~~1.862~~ 1.86

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

Anesthesia services provided by the anesthesiologist medically directing (supervising) five or more certified registered nurse anesthetists or anesthesia residents are paid the lower of:

(1) the submitted charge; or

(2) the physician conversion factor multiplied by four.

Laboratory services are paid using the same methodology as item 3, Other lab and x-ray services.

With the exception of pediatric vaccines in item 2.a., Outpatient hospital services, covering the Minnesota Vaccines for Children program, **vaccines** are paid using the same methodology as item 2.a., Outpatient hospital services.

All other injectables are paid using the same methodology as item 2.a.

❒ monitoring for identification and lateralization of cerebral seizure focus by attached electrodes;

combined electroencephalographic (EEG) and video recording and interpretation each 24 hours are paid the lower of:

(1) submitted charge; or
(2) $751.90

The State has established a rate for the following:

	Procedure Code	Rate
(1)	92340	$ 28.84
(2)	92341	33.99
(3)	V5090	182.15
(4)	V5110	273.23
(5)	V5160	273.23
(6)	V5200	182.15
(7)	V5240	273.23
(8)	X5061	182.15

6.d. Other practitioners' services. (continued)

D. **Administration of anesthesia by certified registered nurse anesthetists (CRNAs)** provided in an outpatient setting are paid the lower of:

(1) submitted charge; or

(2)(a) ~~the Medicare CRNA conversion factor per 15 minute base unit value + 1/15 of the Medicare CRNA conversion factor per one minute time unit,~~ if the services are not provided under the medical direction of an anesthesiologist:

(relative base value units + time units*) x Medicare CRNA conversion factor ; or

(b) ~~($10.72 per 15 minute base unit value) plus ($.71 per one minute time unit)~~ if the services are provided under the medical direction of an anesthesiologist ~~,~~ :

(relative base value units + time units*) x Medicare CRNA conversion factor
2 x 1.264

Hospitals continue to be paid for hospital employed CRNA services as part of the prospective payment system specified for *inpatient* hospital services in Attachment 4.19-A, unless CRNA services were not in the hospital's base rate. If CRNA services are not part of the hospitals' base rate, they are paid as specified in items (1) and (2), above. Hospitals continue to be paid for hospital employed CRNA services through the payment system for *outpatient* hospital services specified in item 2.a. of this Attachment.

Certified registered nurse anesthetist services that are not administration of anesthesia are paid as specified in item 5.a., Physicians' services.

* one time unit equals 15 minutes